		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040709

Facility Name: Alden Lincoln Rehab & H C Ctr

Address: 504 W. Wellington Ave. (Number) Chicago (City) 60657 (Zip Code)

County: Cook

Telephone Number: (773) 281-6200 **Fax #** (773) 281-6745

IDPA ID Number: 36-4003483

Date of Initial License for Current Owners: 03/01/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) STEVEN M. KROLL
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,574	2,783	5,738	17,095	8
9	SNF/PED					9
10	ICF	10,785	2,187	234	13,206	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,359	4,970	5,972	30,301	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.48%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 03/01/95

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 03/01/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 33 and days of care provided 5,355

Medicare Intermediary Administar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	196,010	14,143	6,100	216,253	704	216,957		216,957			1
2	Food Purchase		185,191		185,191	(21,888)	163,303	(13,080)	150,223			2
3	Housekeeping	71,051	23,262		94,313	216	94,529		94,529			3
4	Laundry	53,566	10,542		64,108	73	64,181		64,181			4
5	Heat and Other Utilities			87,855	87,855		87,855	(757)	87,098			5
6	Maintenance	59,067		78,895	137,962		137,962	6,523	144,485			6
7	Other (specify):*											7
8	**TOTAL General Services**	379,694	233,138	172,850	785,682	(20,895)	764,787	(7,314)	757,473			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,143,641	122,831	3,524	1,269,996	1,743	1,271,739	(54,924)	1,216,815			10
10a	Therapy											10a
11	Activities	48,123	1,674	2,192	51,989	88	52,077		52,077			11
12	Social Services	38,698			38,698		38,698		38,698			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,230,462	124,505	15,316	1,370,283	1,831	1,372,114	(54,924)	1,317,190			16
	C. General Administration											
17	Administrative	111,957			111,957		111,957		111,957			17
18	Directors Fees											18
19	Professional Services			390,860	390,860		390,860	(342,957)	47,903			19
20	Dues, Fees, Subscriptions & Promotions			21,933	21,933		21,933	(17,419)	4,514			20
21	Clerical & General Office Expenses	209,775	12,327	56,055	278,157	76	278,233	(1,149)	277,084			21
22	Employee Benefits & Payroll Taxes			255,258	255,258	18,988	274,246	31,557	305,803			22
23	Inservice Training & Education											23
24	Travel and Seminar			253	253		253	6,317	6,570			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			67,699	67,699		67,699	146	67,845			26
27	Other (specify):* **bad debt**			41,239	41,239		41,239	(41,239)				27
28	**TOTAL General Administration**	321,732	12,327	833,297	1,167,356	19,064	1,186,420	(364,744)	821,676			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,931,888	369,970	1,021,463	3,323,321		3,323,321	(426,982)	2,896,339			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr #0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			36,443	36,443		36,443	8,189	44,632			30
31	Amortization of Pre-Op. & Org.							951	951			31
32	Interest			134,278	134,278		134,278	(102,280)	31,998			32
33	Real Estate Taxes			152,143	152,143		152,143	3,791	155,934			33
34	Rent-Facility & Grounds			728,248	728,248		728,248		728,248			34
35	Rent-Equipment & Vehicles			8,370	8,370		8,370	11,643	20,013			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,059,482	1,059,482		1,059,482	(77,706)	981,776			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		292,385	460,785	753,170		753,170	(164,992)	588,178			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		292,385	513,345	805,730		805,730	(164,992)	640,738			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,931,888	662,355	2,594,290	5,188,533		5,188,533	(669,680)	4,518,853			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(296)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,832)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(26,975)	21		17
18	Fines and Penalties	(425)	32		18
19	Entertainment				19
20	Contributions	(1,523)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,199)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(41,239)	27		24
25	Fund Raising, Advertising and Promotional	(14,619)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,108)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(426,448)	Various	34
35	Other- Attach Schedule	(150,124)	Pg 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (576,572)		36
37	**TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)**	$ (669,680)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Lincoln Rehab & H C Ctr

ID# **0040709**

Report Period Beginning: **01/01/2003**

Ending: **12/31/2003**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back out prior year depreciation adj-equipment	$ (4,216)	30	1
2	Reclass vendor settlements from Line 21 to Line 32	(3,179)	32	2
3	Reclass vendor settlements from Line 21 to Line 32	3,179	21	3
4	Back out prior yr cr adj in 7143 for ams therapeutics	3,179	32	4
5	Back out prior yr cr adj in 7143 (ap rec)	4,648	21	5
6	Reclass vendor settlements from Line 21 to Line 6	(1,404)	6	6
7	Reclass vendor settlements from Line 21 to Line 6	1,404	21	7
8	Back out prior yr cr adj in 7143 for Climate Services	1,404	6	8
9	Reclass vendor settlements from Line 21 to Line 10	24,443	10	9
10	Reclass vendor settlements from Line 21 to Line 10	(24,443)	21	10
11	Back out prior yr dr adj in 7143 for Proper Personnel	(24,443)	10	11
12	Illinois Healthcare Association-Pac Fees : 30.13%	(1,562)	20	12
13	Depreciation on Deferred Maintenance "Painting" (Pg 22)	1,069	6	13
14	Late fees on utilities	(2,639)	5	14
15				15
16				16
17	Interest paid to AMS (FAS Interest-GL 7031)	(127,452)	32	17
18	W/G Serv Fee (GL 4977)	(12)	22	18
19	City of Chicago Department of Finance (GL 4977)	(100)	21	19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(150,124)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,832)	0	0	(11,248)	0	0	0	0	0	0	0	(13,080)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,639)	0	1,882	0	0	0	0	0	0	0	0	(757)	5
6	Maintenance	1,069	0	6,111	0	0	0	(25)	(632)	0	0	0	6,523	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,402)	0	7,993	(11,248)	0	0	(25)	(632)	0	0	0	(7,314)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(54,684)	(240)	0	0	0	0	0	0	(54,924)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(54,684)	(240)	0	0	0	0	0	0	(54,924)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,199)	0	(336,758)	0	0	0	0	0	0	0	0	(342,957)	19
20	Fees, Subscriptions & Promotions	(17,704)	0	285	0	0	0	0	0	0	0	0	(17,419)	20
21	Clerical & General Office Expenses	(42,287)	0	16,777	17,462	6,899	0	0	0	0	0	0	(1,149)	21
22	Employee Benefits & Payroll Taxes	(12)	0	29,997	0	1,572	0	0	0	0	0	0	31,557	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,317	0	0	0	0	0	0	0	0	6,317	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	146	0	0	0	0	0	0	0	0	146	26
27	Other (specify):*	(41,239)	0	0	0	0	0	0	0	0	0	0	(41,239)	27
28	**TOTAL General Administration**	(107,441)	0	(283,236)	17,462	8,471	0	0	0	0	0	0	(364,744)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(110,843)	0	(275,243)	(48,470)	8,231	0	(25)	(632)	0	0	0	(426,982)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Alden Lincoln Rehab & H C Ctr** **#** **0040709** **Report Period Beginning:** **01/01/2003** **Ending:** **12/31/2003**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,216)	0	10,584	0	1,821	0	0	0	0	0	0	8,189	30
31	Amortization of Pre-Op. & Org.	0	0	849	0	0	102	0	0	0	0	0	951	31
32	Interest	(128,173)	0	25,105	0	633	155	0	0	0	0	0	(102,280)	32
33	Real Estate Taxes	0	0	3,528	0	263	0	0	0	0	0	0	3,791	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	11,643	0	0	0	0	0	0	0	0	11,643	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(132,389)	0	51,709	0	2,717	257	0	0	0	0	0	(77,706)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(22,687)	(29,777)	(112,528)	0	0	0	0	0	(164,992)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(22,687)	(29,777)	(112,528)	0	0	0	0	0	(164,992)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(243,232)	0	(223,534)	(71,157)	(18,829)	(112,271)	(25)	(632)	0	0	0	(669,680)	45

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	management fees	$ 345,110	Alden Management Services	0.00%	$	$ (345,110)	15
16	V	22	employee benefits		Alden Management Services		29,997	29,997	16
17	V	19	professional fees		Alden Management Services		8,352	8,352	17
18	V	21	gen'l & admin		Alden Management Services		16,777	16,777	18
19	V	5	utilities		Alden Management Services		1,882	1,882	19
20	V	6	maintenance		Alden Management Services		6,111	6,111	20
21	V	24	travel & seminar		Alden Management Services		6,317	6,317	21
22	V	26	insurance		Alden Management Services		146	146	22
23	V	20	dues & subscriptions		Alden Management Services		285	285	23
24	V	30	depreciation		Alden Management Services		10,584	10,584	24
25	V	31	amortization		Alden Management Services		849	849	25
26	V	33	real estate tax		Alden Management Services		3,528	3,528	26
27	V	34	rent-facilities		Alden Management Services				27
28	V	35	rent-equip & vehicles		Alden Management Services		11,643	11,643	28
29	V	32	interest		Alden Management Services		25,105	25,105	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 345,110			$ 121,576	$ * (223,534)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube-feeding	$ 27,111	Pyramid Health Care	0.00%	$ 15,863	$ (11,248)	15
16	V	10	nuersing supplies	59,460	Pyramid Health Care		4,776	(54,684)	16
17	V	39	perdiems/other supplies	49,320	Pyramid Health Care		26,633	(22,687)	17
18	V	21	gen'l & admin		Pyramid Health Care		17,462	17,462	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 135,891			$ 64,734	$ * (71,157)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 108,664	Forum Extended Care II	0.00%	$ 91,800	$ (16,864)	15
16	V	10	house stock	1,547	Forum Extended Care II		1,307	(240)	16
17	V	39	I.V.	83,207	Forum Extended Care II		70,294	(12,913)	17
18	V	22	employee benefits		Forum Extended Care II		1,572	1,572	18
19	V	21	gen'l & admin		Forum Extended Care II		6,899	6,899	19
20	V	32	interest		Forum Extended Care II		633	633	20
21	V	33	real estate tax		Forum Extended Care II		263	263	21
22	V	30	depreciaton		Forum Extended Care II		1,821	1,821	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 193,418			$ 174,589	$ * (18,829)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	tehryapy	$ 453,135	Community Physical Therapy		$ 340,607	$ (112,528)	15
16	V	32	interest		Community Physical Therapy		155	155	16
17	V	31	amortization		Community Physical Therapy		102	102	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 453,135			$ 340,864	$ * (112,271)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	repairs and maintenance	$ 7,681	Alden Bennett Construction		$ 7,656	$ (25)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,681			$ 7,656	$ * (25)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	CARPET CLEANING	$ 690	ALDEN REALTY - CARPET CARE		$ 642	$ (48)	15
16	V	6	FLOOR CLEANING	10,290	ALDEN REALTY - FLOOR CARE		9,706	(584)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,980			$ 10,348	$ * (632)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALDEN NURSING CENTER - LINCOLN PARK # 004-0709 Report Period Beginning 01/01/03 Ending: 12/31/03

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Waterford	Aurora
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingdale
ANC Village for Children & Young Adults	Bloomingdale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingdale
Alden of Old Town West	Bloomingdale
Alden Trails	Bloomingdale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governors' Park	Barrington

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Floyd A. Schlossberg	President		100.00	336,770	1.128	2.82	SALARY	$ 9,782	17-1	1
2	Lauren Magnussen	Clinical Coordinator		A	84,607	1.128	2.82	SALARY	2,458	10-1	2
3	Terry Magnussen	Maintenance Supr		A	81,818	1.128	2.82	SALARY	2,376	6-1	3
4											4
5											5
6	a. President and sole stockholder of Alden Management Services, Inc.										6
7	b. Daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	c. Son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 14,616		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson Ave.
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773) 286-3883
Fax Number: (773) 286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see page 8A (also on page 6A)				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	related party-ams& ams therap	x		working capital							31,506	6
7	related party-cpt	x		working capital							155	7
8	related party-fecII	x		working capital							633	8
9	TOTAL Facility Related						$	$			$ 32,294	9
	B. Non-Facility Related*											
10	offset Interest expense with Interest Income (GL4964,4983)										(296)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (296)	14
15	TOTALS (line 9+line14)						$	$			$ 31,998	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr **#** 0040709 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	153,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	150,743	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,857)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	155,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	152,143	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	162,271	8
	1999	161,182	9
	2000	145,292	10
	2001	149,072	11
	2002	150,743	12

accrual based on 3% increase over prior yr bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Lincoln Rehab & H C Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040709

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 286-3883 FAX #: (773) 286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-108-023-0000	Nursing home facility	$ 150,743.00	$ 150,743.00
2.		Related Party - Alden Management	$ 125,008.00	$ 3,528.00
3.		Related Party - Forum	$ 8,317.00	$ 263.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 284,068.00	$ 154,534.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,252 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [x] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	$ 15,909	$	22	$	$	$ 15,909	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler heads			1995	1,832	73	25	73		605	9
10	Roof repairs			1995	2,000	200	10	200		1,633	10
11	Installed Electric AMPS			1996	1,870		5			1,870	11
12	Signs			1996	1,800	180	10	180		1,335	12
13	Water Heater			1997	6,180		5			6,180	13
14	Replace Pipes			1997	5,949		5			5,949	14
15	Exhaust Fans			1997	8,403		5			8,403	15
16	Washing machine motor			1998	1,576	197	8	197		1,149	16
17	ABC (General construction) Major repairs/improvement			1999	5,713	571	10	571		2,571	17
18	ABC (General construction) Major repairs/improvement			1999	2,326	233	10	233		1,027	18
19	ABC (General construction) Major repairs/improvement			1999	2,092	209	10	209		924	19
20	ABC (General construction) Major repairs/improvement			1999	1,870	187	10	187		779	20
21	ABC (General construction) Major repairs/improvement			1999	12,658	1,266	10	1,266		5,274	21
22	ABC (General construction) Major repairs/improvement			1999	2,250	225	10	225		919	22
23	ABC (General construction) Major repairs/improvement			1999	10,225	1,022	10	1,022		4,175	23
24	Climate Services (exhaust fan)			1999	2,280	456	5	456		1,938	24
25	Oxygen exhaust system			2000	8,555	1,069	8	1,069		4,188	25
26	Elevator door repair			2000	1,518	304	5	304		1,063	26
27	Lawn Sprinkler			2000	15,500	620	25	620		2,067	27
28	ABC (General construction) Major repairs/improvement			2000	6,937	1,387	5	1,387		4,393	28
29	ABC (General construction) New hot water system			2000	49,596	2,480	20	2,480		9,506	29
30	ABC (General construction) Replace showers			2000	23,903	2,390	10	2,390		7,968	30
31	Replace Fire Pump			2001	3,230	162	20	162		485	31
32	14 Kilowatt water heater booster			2001	2,783	278	10	278		649	32
33	ABC (General construction) Major repairs/improvement			2001	3,402	680	5	680		1,701	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Capps Plumbing (pipe & wall repair)	2002	$ 1,985	$ 397	5	$ 397	$	$ 496	37
38	ABC (misc construction work)	2002	3,442	688	5	688		918	38
39	ABC (repair ejector pump)	2002	7,893	1,579	5	1,579		1,973	39
40	Capps Plumbing (water pump)	2002	3,275	164	20	164		232	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 216,952	$ 17,018		$ 17,018	$	$ 96,280	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 216,952	$ 17,018		$ 17,018	$	$ 96,280	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	16,755		20			16,755	4
5	Leasehold Improvement-Remodeling	1980	1,047		10			1,047	5
6	Leasehold Improvement-Remodeling	1986	559		5			559	6
7	Leasehold Improvement-Remodeling	1990	350		5			350	7
8	Leasehold Improvement-Remodeling	1991	82		5			82	8
9	Leasehold Improvement-Remodeling	1993	7,732		10			7,732	9
10	Leasehold Improvement-Remodeling	1993	6,056		9.7			6,056	10
11	Leasehold Improvement-sign	1994	226	14	12	14		120	11
12	Leasehold Improvement-dryvit	1995	384	24	10	24		203	12
13	Leasehold Improvement-new ac	1999	626	39	15	39		203	13
14	Leasehold Improvement-roof	1985	843	44	19	44		843	14
15	Leasehold Improvement-roof	1994	748	47	15	47		529	15
16	Leasehold Improvement-roof	1997	710	44	15	44		349	16
17	Leasehold Improvement-roof	1998	1,205	75	15	75		507	17
18	Leasehold Improvement-parking lot asphalt	2000	96	32	10	32		63	18
19	Leasehold Improvement-hallway lighting	2001	135	27	10	27		56	19
20	Leasehold Improvement-DAI	2001	169	17	10	17		53	20
21	Leasehold Improvement-bathrooms	2002	630	63	10	63		80	21
22	Leasehold Improvement-Remodeling	2002	91	18	5	18		36	22
23	Leasehold Improvements-Remodeling	2003	1,638	164	10	164		164	23
24	Leasehold Improvements-Remodeling	2003	105	4	4	4		4	24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,132		7			6,132	27
28	Leasehold Improvement-Remodeling	2002	5,020	627	7	627		4,392	28
29	Leasehold Improvement-Remodeling	2003	5,251	660	7	660		4,611	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	15,137	378	40	378		1,896	33
34	TOTAL (lines 1 thru 33)		$ 288,679	$ 19,295		$ 19,295	$	$ 149,102	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 216,762	$ 20,129	$ 20,129	$	varies	$ 124,894	71
72	Current Year Purchases	21,677	1,548	1,548		varies	1,548	72
73	Fully Depreciated Assets	67,294	1,608	1,608		varies	67,297	73
74								74
75	TOTALS	$ 305,733	$ 23,285	$ 23,285	$		$ 193,738	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/other	:dodge/other	98-'03	$ 11,860	$ 2,052	$ 2,052	$	3	$ 11,658	76
77										77
78										78
79										79
80	TOTALS			$ 11,860	$ 2,052	$ 2,052	$		$ 11,658	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 606,272	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 44,632	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 44,632	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 354,498	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$ n/a	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ n/a	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: TL Enterprises

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		96	3/1/95	$	15		3
4	Additions							4
5								5
6								6
7	TOTAL		96		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [x] YES [ ] NO Terms: purchase option deposit *

10. Effective dates of current rental agreement:
Beginning 3/1/95
Ending 3/1/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$ 728,248
13.	/2005	$ 728,248
14.	/2006	$ 728,248

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 8,370 Description: Copy machine lease + Postage Meter Rental
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19	related party - AMS	various	970.25	11,643	19
20					20
21	TOTAL		$ 970.25	$ 11,643	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Skilled nurses on site

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 226,294	$		$ 226,294	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			16,719			16,719	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			210,120			210,120	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Page 16A	# of prescrpts				79,884		79,884	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See Page 16A					55,161		55,161	13
14	TOTAL			$		$ 453,133	$ 135,045		$ 588,178	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 87,000)	741,406		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,411		6
7	Other Prepaid Expenses	848		7
8	Accounts Receivable (owners or related parties)	1,836,378		8
9	Other(specify): Due from 3rd parties	67,588		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,654,631	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	281,355		15
16	Equipment, at Historical Cost	180,158		16
17	Accumulated Depreciation (book methods)	(247,652)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	98,860		21
22	Other Long-Term Assets (spe Purchase Options	288,000		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 600,721	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,255,352	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,245,610	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	222,837		28
29	Short-Term Notes Payable	33,612		29
30	Accrued Salaries Payable	162,288		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,383		31
32	Accrued Real Estate Taxes(Sch.IX-B)	155,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accr ins, exps,idpa,sales tax, etc	349,115		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,176,845	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	48,761		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 48,761	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,225,606	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,029,746	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,255,352	$	48

***(See instructions.)**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,060,328	1
2	Restatements (describe):		2
3	external audit adjustments made after 2001 cost report was		3
4	submitted. These have no effect on prior years report :	(81,996)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 978,332	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	51,414	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 51,414	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,029,746	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,845,116	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,845,116	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	80,229	6
7	Oxygen	13,434	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 93,663	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	315	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,472	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	814	19
20	Radiology and X-Ray	(1)	20
21	Other Medical Services	66,576	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 75,176	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	296	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 296	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Various-See attached	177	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 177	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,014,428	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	785,682	31
32	Health Care	1,370,283	32
33	General Administration	1,167,356	33
	B. Capital Expense		
34	Ownership	1,059,482	34
	C. Ancillary Expense		
35	Special Cost Centers	753,170	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37	Related Party Salary Allocations	(225,519)	37
38	located in Column 1 on pages 3 & 4		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,963,014	40
41	**Income before Income Taxes (line 30 minus line 40)****	51,414	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 51,414	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,580	2,709	$ 71,701	$ 26.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,737	10,600	278,696	26.29	3
4	Licensed Practical Nurses	13,211	13,793	266,587	19.33	4
5	Nurse Aides & Orderlies	43,889	47,539	448,472	9.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,040	2,112	33,442	15.83	9
10	Activity Assistants	1,764	1,807	14,681	8.12	10
11	Social Service Workers	1,944	2,056	38,698	18.82	11
12	Dietician					12
13	Food Service Supervisor	2,004	2,084	37,257	17.88	13
14	Head Cook	1,896	2,032	25,677	12.64	14
15	Cook Helpers/Assistants	13,281	14,886	130,238	8.75	15
16	Dishwashers					16
17	Maintenance Workers	2,056	2,152	47,456	22.05	17
18	Housekeepers	5,885	6,370	66,807	10.49	18
19	Laundry	6,468	6,868	53,566	7.80	19
20	Administrator	2,024	2,080	72,248	34.73	20
21	Assistant Administrator					21
22	Other Administrative	1,848	2,080	40,332	19.39	22
23	Office Manager					23
24	Clerical	2,305	2,403	19,973	8.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,629	1,629	42,515	26.10	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Alzheimers Aide	1,880	1,928	18,023	9.35	33
34	TOTAL (lines 1 - 33)	116,441	125,128	$ 1,706,369 *	$ 13.64	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,100	1-3	35
36	Medical Director	Monthly	9,600	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,304	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,312	11-3	44
45	Social Service Consultant	16	880	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	40	$ 20,196		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Sagaidoro, Tess	administrator		72,248
related party-various			
executives	exec mgmnt		39,709

TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) $ 111,957

B. Administrative - Other

Description	Amount
	$

TOTAL (agree to Schedule V, line 17, col. 3) $

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
		$
AMS	Management Fees	345,110
BDO Seidman	Accounting Fees	10,196
Kenneth Fisch	Legal Fees	11,920
Medi.Com	Billing Consultants	188
Wellington Plaza	Legal Fees	5,000
Janet Hermann/Barry Greenburg	Legal Services	3,670
Others: Ams/Talx/	Unemployment Consultants	267
Madelon Bonnie Saltzman	Placement Services	11,000
Schmidt Salzman & Moron	Legal Services	1,529
Adminastar Federal	Billing Services	1,980

TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.) $ 390,860

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,854
Unemployment Compensation Insurance	16,195
FICA Taxes	130,373
Employee Health Insurance	17,501
Employee Meals	21,888
Illinois Municipal Retirement Fund (IMRF)*	
related party-fecII & ams	31,569
Chicago Head Tax	3,683
Union Health & Welfare	25,671
Dental,Life & Pension	12,875
Misc, Tution	647
Drug Tests, Vaccinations	1,547
TOTAL (agree to Schedule V, line 22, col.8)	$ 305,803

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	413
Health Care Worker Background Check	
(Indicate # of checks performed 12)	84
IL. Healthcare Assoc.	3,622
Surety Bond Fees, Dues & Subscriptions	110
related party-ams	285
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,514

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
related party-ams	6,317
Misc Gas	243
Seminar Expense	10
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,570

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Climate Service-Pipeing	9/95	$ 1,809	5	$ 241	$ 0	$	$	$	$	$	$	$
2	Painting	9/95	2,478	3									
3	Painting	11/95	4,500	3									
4	Painting	12/95	1,497	3									
5	Onassis (painting)	1/96	1,369	3									
6	Climate Service, Inc.(boil)	1/96	2,015	15	134	134	134	134	134	134	134	134	134
7	Onassis (painting)	2/96	1,541	3									
8	Great Lakes Plumbing(fix	3/96	1,739	20	87	87	87	87	87	87	87	87	87
9	Onassis (painting)	3/96	1,360	3									
10	Superior Painting & Déco	3/96	3,400	3									
11	Superior Painting & Déco	5/96	1,626	3									
12	Superior Painting & Déco	6/96	1,534	3									
13	Superior Painting & Déco	7/96	1,566	3									
14	Superior Painting & Déco	7/96	1,671	3			continued on page 22A, includes grand total…						
15	Superior Painting & Déco	8/96	1,627	3									
16	Superior Painting & Déco	9/96	907	3									
17	Superior Painting & Déco	9/96	950	3									
18	Building Plumbing &Heat	10/96	1,831	15	122	122	122	122	122	122	122	122	122
19	Onassis (painting)	12/96	1,606	3									
20	TOTALS		$ 35,026		$ 584	$ 343	$ 343	$ 343	$ 343	$ 343	$ 343	$ 343	$ 343

Facility Name & ID Number: Alden Lincoln Rehab & H C Ctr | 0040709 | Report Period Beginning: 01/01/2003 | Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	6	7	8	9	10	11	12	13	14
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Climate Serv (repair boiler)	Feb-97	1,644	3	46								
2	Climate Serv (repair/insulate pip	Apr-97	2,348	3	195								
3	Climate Serv(insulation-remove	Jun-97	3,865	3	537								
4	Climate Serv(install circulating p	Sep-97	2,585	3	574								
5	Appliance(air conditioning for ki	Aug-97	2,412	3	469								
6	Great L.P.(remove & install pum	Dec-97	2,595	3	793								
7	Appliance C.(a/c for kitchen)	May-98	3,702	3	1,234	411							
8	CSI(install ductwork for dryer ex	Sep-98	2,670	3	890	593							
9	Custom A.C. (carpeting)	Dec-98	2,940	3	980	898							
10	Custom A.C.	Dec-98	192	3	64	59							
12	ABC(repair floor and roof)	9/00	10,285	3	1,143	3,428	3,428	2,286					
13	ABC(misc. construction job)	11/00	8,927	3	496	2,975	2,976	2,480					
14	GT Mechanical(replace motor)	11/02	1,122	3			62	374	374	312			
15	Painting > $1,500 --1999	7/99	11,700	3	3,900	3,900	1,950						
16	Painting > $1,500 --2000	7/00	6,413	3	1,069	2,138	2,138	1,069					
17													
18													
19	Totals from Page 22 . . .		35,026		584	343	343	343	343	343	343	343	343
20	GRAND TOTALS		98,425		12,974	14,747	10,897	6,552	717	655	343	343	343

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **yes**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IL Healthcare Assoc. $5,184**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,477** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **no** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **52,560**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,888** Has any meal income been offset against related costs? **no** Indicate the amount. $ **n/a**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **BDO Seidman, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Reporting Period Beginning 1/01/03
Reporting Period Ending 12/31/03

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(21,888)	Employee Meal
	22	21,888	Employee Meal
22		(2,900)	Uniforms
	10	1,743	Uniforms
	6		Uniforms
	4	73	Uniforms
	1	704	Uniforms
	3	216	Uniforms
	11	88	Uniforms
	21	76	Uniforms
		0	Net should be 0